REPORT OF THE
AD HOC COMMITTEE ON

THE ROLE OF REGIONAL BOARDS
OF HEALTH

Submitted to
The Honourable Graham Taylor,
Minister of Health

JUNE, 1984

TABLE OF CONTENTS

	PAGE
Committee Membership	(i)
1. Introduction and Terms of Reference	1
2. Summary of Recommendations	4
3. Orientation, Education and Consultation	7
4. Organization, Representation and Role	10
5. Funding	21
6. Legislation	24
7. Conclusion	27
Appendix I - Review of Existing Legislation	28
Appendix II - Map of Health Regions	30

MEMBERS OF THE AD HOC COMMITTEE

G.H. Loewen - Chairman
Associate Deputy Minister of Health

L. Birkbeck
MLA Moosomin and
Legislative Secretary to
the Minister of Health

Dr. J. Burkholder
Medical Health Officer
Moose Jaw-Assiniboia-
Gravelbourg Health Region

L. Gisi
Chairman
Prince Albert Health Region

L. Grondin
Chairperson
Rosetown-Biggar-Kindersley
Health Region

J. Kurtz
Chairman
Swift Current Health Region

S. Malach
Executive Director
Community Health Services Branch
Saskatchewan Health

F. Scott
Chairman
North Battleford Health Region

J. Thorn
Administrator
Prince Albert Health Region

N. Yeates - Secretary
Policy Analyst
Saskatchewan Health

1) INTRODUCTION

The Ad Hoc Committee was struck by the Minister of Health in January, 1984. In November, 1982 a "Special Committee of the Chairmen of Boards of Health in Saskatchewan" submitted a brief to the Minister identifying a number of concerns about the role of regional boards of health. It was argued that the power and influence of regional boards has diminished over the years, but that nonetheless, these bodies have an important role to play in the operation of public health programs. The Special Committee recommended that a committee be established to review the role of regional boards.

The Ad Hoc Committee adopted the following terms of reference:

a) Examine current legislation regarding health region boards, their function and their selection, and make recommendations regarding any changes thought to be desirable.

b) Review current role of district councillors and regional board members, and propose ways in which they might play a more effective role in the delivery of community health services.

c) Make recommendations regarding education and orientation requirements of district health councillors and health region board members.

The terms of reference were somewhat expanded to include the public health responsibilities of municipal councils ("Boards of Health").* Public health services in the cities of Regina and Saskatoon were excluded since they are administered directly by the two cities.

Health regions were first created in Swift Current and Weyburn-Estevan in 1945. By 1961 the province was organized into 13 health regions, but this number was later reduced to 10. Health region boards were granted extensive powers under The Public Health Act and The Health Services Act. These powers include the supervision of "health services" in the region. Health services, as defined in the legislation, can include hospitals, health centres, and medical and surgical services. Regional boards were given the authority to employ staff and requisition taxes from

* In The Public Health Act the board of health is the municipal council. Cities, however, have the option of appointing a committee of council to act as the board of health (see Section 15). The term "municipal council" is used to refer to boards of health in this report.

local governing authorities. These powers were used extensively by the Swift Current health region to operate a hospital, medical and dental program until relatively recently.

Regional boards have evolved to become largely advisory in nature due to a number of changes in the health care system. With the exception of the Cities of Regina and Saskatoon, public health programs are operated on a uniform basis throughout the province, and are funded almost completely by the provincial government. Staffing, budgeting and resource allocation is undertaken on a centralized basis. Most other health programs are now delivered on a decentralized basis, operating under the direction of local boards such as hospital, special-care home, home care and ambulance boards. Within the context of provincial guidelines, these boards are responsible for the delivery of services.

The Ad Hoc Committee accepts the view that regional boards of health cannot expect to perform a role as outlined in current legislation. Clearly the legislation has become dated in light of other

developments in the health care system. However, all Committee members agreed that useful roles should be established for regional boards and district health councils, or these bodies should be disbanded.

The remainder of the report discusses and makes recommendations concerning four major areas:

1) Orientation, Education and Consultation
2) Organization, Representation and Role
3) Funding
4) Legislation

The Ad Hoc Committee met on four occasions from January to May, 1984. Input was solicited from all regional boards, and from the Saskatchewan Public Health Association, the Saskatchewan Urban Municipalities Association and the Saskatchewan Association of Rural Municipalities.

2) SUMMARY OF RECOMMENDATIONS

1) That annual consultations between the Minister and the Chairmen of Regional Boards take place.

2) That an annual meeting be held between the Chairmen of Regional Boards and the Executive Director of Community Health Services Branch.

3) That Community Health Services Branch prepare an orientation and policy manual outlining the public health responsibilities and roles of regionalboards, municipal councils, and Community Health Services Branch. The manual should be distributed to all regional board members, and copies should be available in health region offices.

4) That a one-day education seminar be held in each health region on an annual basis for all board members and municipal health representatives.

5) That District Health Councils be disbanded.

6) That district health councillors be referred to as municipal health representatives.

7) That municipal health representatives attend the annual meeting of the health region.

8) That all municipalities be permitted to form a committee of council to act as the board of health.

9) That regional boards have no less than 5 and no more than 10 members.

10) That regional boards be given a renewed mandate to perform the following functions:
   a) advisory
   b) investigation
   c) advocacy
   d) planning and development

11) That regional boards be provided with funds for the operation of pilot projects as approved by the Minister of Health.

12) That a formal appeal process be established for complaints regarding the application of public health standards and regulations.

13) That municipal councils be encouraged to utilize regional boards for hearing appeals, suggesting changes in legislation, and identifying program needs.

14) That Community Health Services Branch be given sufficient funding to permit 6 regional board meetings per year plus an annual health region seminar, an annual meeting, and 2 meetings of regional board chairmen.

15) That municipalities assume responsibility for the payment of honorariums and expenses for municipal health representatives.

16) That municipal contributions be increased to $1.00 per capita.

17) That the Public Health Act and The Health Services Act be revised to reflect the proposed role of regional boards and municipal councils in public health.

3) ORIENTATION, EDUCATION AND CONSULTATION

At present there are no formal orientation or education programs for regional board members or district health councillors. While some education and orientation may be provided by particular health regions, there is no uniformity. District Health Councillors attend the annual meeting of the health

region which may serve to familiarize councillors with public health programs.

The current level of orientation and education does not appear satisfactory for effective functioning of regional boards. Training should serve to generate an awareness of the following elements: the goals of public health, existing public health programs, legislative responsibilities, and the roles of boards and municipal councils in the Community Health Services' system. Some orientation and inservice education can be provided in conjunction with health region annual meetings.

The Chairmen of Regional Boards hold an annual meeting in conjunction with the Community Health Services Branch field staff conference. The Minister of Health is invited to the meeting to address the Chairmen, and listen to whatever concerns they may have. Consultations with the Minister are considered valuable. However, it would also be useful for Board Chairmen to meet annually with the Executive Director of Community Health Services Branch. This meeting could be scheduled for some time in the fall. Unlike other groups (e.g. the Saskatchewan School Trustees

Association and the Saskatchewan Health-Care Association), regional board members do not meet as a whole.

Recommendations

1) That annual consultations between the Minister and the Chairmen of Regional Boards take place.

2) That an annual meeting be held between the Chairmen of Regional Boards and the Executive Director of Community Health Services Branch.

3) That Community Health Services Branch prepare an orientation and policy manual outlining the public health responsibilities and roles of regional boards, municipal councils, and Community Health Services Branch. The manual should be distributed to all regional board members, and copies should be available in health region offices.

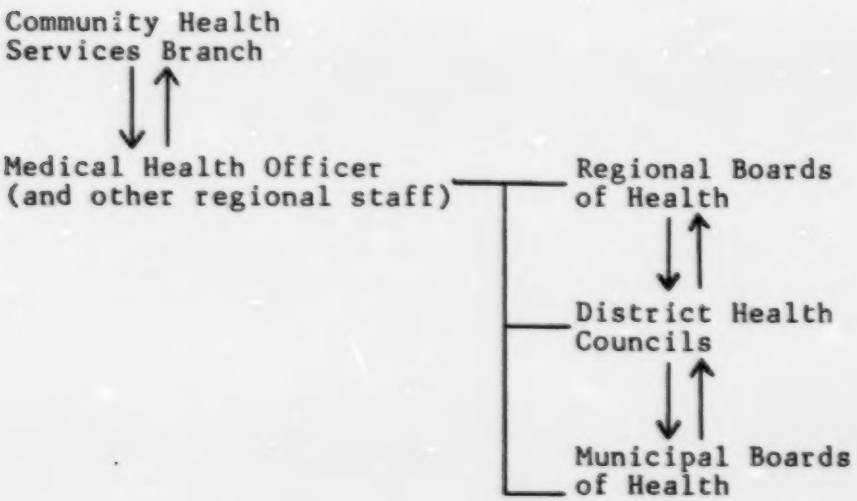
4) That a one-day education seminar be held in each health region on an annual basis for all board members and district health councillors (municipal health representatives).*

* It is recommended later in this report that the title of district health councillors be changed to municipal health representatives.

4) ORGANIZATION, REPRESENTATION AND ROLE

a) Organization and Representation

The current structure of regional boards of health and district health councils can be illustrated as follows:


Community Health Services Branch
Medical Health Officer (and other regional staff)
Regional Boards of Health
District Health Councils
Municipal Boards of Health

At present there are 87 regional board members and 802 district councillors. The diagram above indicates that, in organizational terms at least, policy flows from regional boards to district councils to municipal boards. Input and feedback flow in the opposite direction. All three bodies interact with the Medical Health Officer and other regional staff. Regional staff receive direction from, and provide feedback to, Community Health

Services Branch. Regional Boards have some contact with the Minister of Health and central office staff of Community Health Services Branch. The Minister, while not shown in the diagram, is, of course, ultimately responsible for Community Health Services.

From an organizational point of view, the existing structure appears fairly logical and straightforward. In practical terms, however, there are a number of difficulties. District health councillors are appointed by municipalities, but there are no specific responsibilities associated with the position. As a result, district health councils rarely meet, and attendance is frequently poor. Most councils only meet once a year to appoint a member to the regional board. Not surprisingly, there is minimal interaction between district health councils and the other bodies involved in public health (regional boards, municipal councils and regional staff). Thus, district health councils are effectively bypassed. The role of a district health councillor (as opposed to council) will vary

according to the interest of the individual, and the use made of the position by the municipal council. Thus, there is a wide variation in roles across the province.

A number of options for changing the organization and representation of regional boards and district councils were considered by the Committee, including the following:

- require board and council members to be elected municipal councillors;
- require interest group representation on regional boards (e.g. senior citizens, natives, etc.);
- remove the geographic basis for appointment to regional boards;
- disband district health councils;
- reduce the size of regional boards to a more manageable level.

While all of these options have some merit, the Committee is of the view that only the last two should be implemented at this time. The primary difficulty faced by both regional boards and

district health councils has been the lack of a clearly defined mandate or role. As noted earlier, district health councils do not appear to have a significant role in public health. It is proposed that district health councils be disbanded, but that municipalities continue to appoint representatives to attend the annual meeting of the health region to nominate a regional board, and to participate in education sessions. In order to avoid confusion with district health councils, it is proposed that district health councillors be referred to as municipal health representatives. This title also emphasizes their responsibility to municipalities.

Health districts should be maintained for the election of regional board members. In this manner regional boards will continue to be geographically representative of the health region. Municipal councils may wish to delegate responsibility for public health matters to a member of council, or may wish to appoint a member of the general public with an interest in public health as their municipal health representative.

As noted earlier in the report, cities have the option of forming a sub-committee of council to act as the board of health. It is proposed that other municipalities also be given this option. Some minor legislative changes would be required.

The number of representatives on a regional board is determined by the number of districts within the health region, and the number of representatives for each district (most districts have 1 representative). There are substantial variations in the size of regional boards between health regions. The size of boards by health region is as follows:

Health Region	No. of Members	Population*	Ratio+
Swift Current	12	49,007	1:4084
Moose Jaw	14	69,557	1:4968
Weyburn-Estevan	10	51,073	1:5107
Regina Rural	5	74,874	1:14975
Rosetown	6	41,522	1:6920
Saskatoon Rural	7	48,775	1:6968
Yorkton-Melville	6	83,154	1:13859
Melfort-Tisdale	11	74,707	1:6792
Prince Albert	7	79,064	1:11295
North Battleford	10	81,035	1:8104

*Saskatchewan Hospital Services Plan Population, 1983
+Population per board member

It is evident that the size of regional boards does not correspond in any uniform manner to the health region populations. The larger boards are generally the result of the amalgamation of 2 health regions. Furthermore, representation is at best indirect. Therefore, it is proposed that the maximum board size be 10 members with a minimum of 5. This would result in a reduction of at least 7 regional board member positions, and would require a re-definition of health district boundaries. The most feasible means of effecting reductions in the size of boards and changing health districts would be to request proposals from the boards themselves.

Recommendations

5) That District Health Councils be disbanded.
6) That district health councillors be referred to as municipal health representatives.
7) That municipal health representatives attend the annual meeting of the health region.
8) That all municipalities be permitted to form a committee of council to act as the board of health.
9) That regional boards have no less than 5 and no more than 10 members.

b) Role

As noted earlier, the Committee supports the view that the roles of regional boards and municipal councils need to be clearly outlined if these bodies are to play an effective role in public health. The proposed roles of regional boards and municipal councils are discussed in detail below.

Regional Boards

The role of regional boards can be divided into four main areas: advisory, investigation, advocacy, and planning and program development.

Advisory

- provide advice and make recommendations to municipal councils

- liaison with municipal councils on a regular basis

- liaison with Community Health Services Branch

- make recommendations to the Minister of Health, or other Ministers as deemed appropriate

Investigation

- investigate complaints and follow-up on problem areas in co-operation with the Regional Director

- bring isues to the attention of Community Health Services Branch staff and municipal councils

- act as an Appeal Board for complaints regarding the application of public health standards and regulations prior to complaints being taken to the Minister of Health

Advocacy

- support public health, health promotion activities and public health legislation

- attend seminars and workshops in local communities

- assist in public education on public health matters (e.g. increase public awareness of regional boards)

- develop media contacts; make presentations to groups

Planning and Program Development

- assess public health programs

- conduct surveys and undertake research projects concerning program needs

- make recommendations to the Minister of Health on program changes

- ongoing review of existing legislation

- design and operate pilot projects to meet local public health needs

Two of the functions proposed for regional boards require discussion: the appeal process and public health pilot projects. The suggested procedure for appeals is outlined in Section 6, Legislation. In order to foster local initiatives in public health, the Committee proposes that regional boards be provided with a limited amount of discretionary funds with which they may operate pilot projects. The amount of funds to be provided, and possible funding mechanisms, is discussed in Section 5, Funding. It

is proposed that a pool of funds be made available for these projects, and that applications be submitted to the Minister of Health. Projects would be of a temporary nature, and it is expected that evaluations would be undertaken.

Municipal Councils (Boards of Health)

Municipal councils have been given substantial responsibility for public health through a number of pieces of legislation (Public Health Act, Health Services Act, and The Rural and Urban Municipalities Acts). Councils have the power to make their own bylaws, and are required to enforce existing legislation and regulations. Thus, councils have important regulatory and control functions. As a result, councils frequently deal directly with regional Community Health Services' staff in addressing public health problems. It is suggested that municipal councils be encouraged to consult their regional board regarding such matters as hearing of appeals, concerns regarding legislation, and identification of program needs.

It has been recommended that district health councils be disbanded, but that municipalities send a "municipal health representative" to the annual meeting of their health region. It is proposed that the responsibilities of municipal health representatives be identical, at the local level, to the advisory, investigation, and advocacy functions of regional boards. The municipal health representative can serve as an important liaison between the municipality and the regional board. In addition, there needs to be a formal mechanism to ensure that municipal health representatives report on a regular basis to municipal councils or their board of health. It is suggested that appointed representatives attend meetings where public health matters are discussed. Reporting to council is a relatively straightforward matter for municipal health representatives who are also members of the municipal council.

Recommendations

10) That regional boards be given a renewed mandate to perform the following functions:
    a) advisory
    b) investigation

c) advocacy

d) planning and development

11) That regional boards be provided with funds for the operation of pilot projects as approved by the Minister of Health.

12) That a formal appeal process be established for complaints regarding the application of public health standards and regulations.

13) That municipal councils be encouraged to utilize regional boards for hearing appeals, suggesting changes in legislation, and identifying program needs.

5) FUNDING

There are three issues to be considered in the realm of funding: board expenses, municipal contributions and funds for pilot projects. Regional board and district health council members are paid on honourarium of $45 for each meeting they attend as well as travel and sustenance at government rates. Health regions are generally funded according to their previous experience (i.e. number of board and council members and number of meetings held

annually). In 1983-84 approximately $60,000 was required for this purpose. It is proposed that regional boards be funded for 6 meetings per year, as well as an annual health region education seminar and an annual meeting. In addition, provision should be made for 2 meetings per year for regional board chairmen. In order to increase the accountability of municipal health representatives, it is proposed that municipalities assume responsibility for the payment of expenses and honorariums for these individuals. Such costs would likely not exceed $200 annually.

Municipal contributions for public health services have been fixed at 50¢ per capita since the 1940's. In 1964-65 these contributions represented 17.1% of total health region expenditures, but have since declined to 3% and will continue to decline further. If municipal contributions were to return to 1964-65 levels, the per capita amount would be approximately $2.80. It is proposed that the municipal per capita levy be increased to $1.00, and that half of this amount be made available to regional boards for the operation of pilot projects. The total amount available would be approximately $375,000. The amount of funding for an individual

health region would not exceed 50¢ per capita unless there were surplus funds available. The municipal levy itself has become somewhat of an anachronism given that the province administers and operates all public health programs. However, given the importance of municipal interest in this area, these contributions should be maintained.

Recommendations

14) That Community Health Services Branch be given sufficient funding to permit 6 regional board meetings per year plus an annual health region seminar, an annual meeting, and 2 meetings of regional board chairmen (costs will not exceed current funding levels).

15) That municipalities assume responsibility for the payment of honouariums and expenses for municipal health representatives.

16) That municipal contributions be increased to $1.00 per capita.

6) LEGISLATION

During the course of the Committee's deliberations it became evident that existing legislation pertaining to regional boards and district health councils requires significant revisions. The Committee is aware of the legislative review process currently in place in the Department of Health. The Committee was given the opportunity to review a draft of a combined Public Health Act and Health Services Act. Overall, the Committee believes that the legislation should be updated to reflect the proposed role of regional boards, and that all references to district health councils should be deleted. This section will provide a general overview of the legislative changes required. A more detailed review of specific sections can be found in Appendix I.

As noted earlier, existing legislation confers substantial powers upon regional boards, many of which are no longer required. Regional boards are given powers over health services generally whereas their jurisdiction should be restricted to public health services. Thus, boards would no longer have the authority to operate hospitals or provide medical services. Boards are currently required to submit annual estimates of

expenditures to the Minister of Health. However, boards are only involved in budgeting in an advisory capacity, and legislation should reflect this.

The mandate of regional boards needs to be clearly outlined in legislation. Two areas require particular attention: the appeal function, and the operation of pilot projects. A brief reference is made to appeals under regulations of The Health Services Act (Section 10, viii, ix). This section indicates that the regional board may act as a "Board of Referees" in cases of dispute, and may refer to the Minister for advice on such cases. It is proposed that the regional board serve as an "Appeal Board". Therefore, anyone wishing to appeal a decision of regional staff or of a municipal council may present their case to the regional board. Examples of possible complaints include the abatement of a nuisance and the placarding of a dwelling. The regional board would hear the arguments of both sides and hand down a decision on the matter. The decision of the regional board could, if required, be appealed to the Minister of Health. It is intended that complaints will be dealt with first by the administering body (regional staff or municipal council), then by the regional board, and finally by the Minister.

There are a number of sections in The Health Services Act relating to taxation authority and the submission of estimates of expenditures to the Minister of Health. It is proposed that these sections be combined in a new section authorizing regional boards to operate pilot projects. Applications for funds for these projects would be made to the Minister. Annual reports on pilot projects would be submitted to the Minister. Regional boards should retain the right to requisition funds from local governing authorities in order that additional expenditures can be made on public health services if so desired. It is unlikely, however, that requisitioning of this type will occur. Since regional board members are ultimately representatives of municipalities, it can be assumed that agreement on requisitioning will be obtained should it occur.

Finally, there are sections in both The Public Health Act and The Health Services Act relating to the involvement of municipal councils in public health services. Many of these sections are no longer required. Municipal councils are given authority to act on public health matters in both The Rural and Urban Municipality Acts. These Acts should be reviewed to avoid unnecessary duplication with health legislation.

Recommendation

17) That The Public Health Act and The Health Services Act be revised to reflect the proposed roles of regional boards and municipal councils in public health.

6) CONCLUSION

The new role for regional boards outlined in this report has been developed in order to rejuvenate these bodies. The recommendations concerning orientation, education and consultation are intended to increase support for regional boards by the Department of Health. Educating members is seen as crucial in increasing effectiveness. The Committee believes that regional boards should be evaluated on an ongoing basis to determine what progress is being made. If the measures recommended here do not have the intended effect, then further changes should be considered. Boards can be evaluated on the basis of the interest and action they are able to generate in their regions in public health. The Committee is optimistic, however, that positive changes will be forthcoming.

APPENDIX I - REVIEW OF LEGISLATION

The Committee supports the amalgamation of The Public Health and Health Services Acts. The development of a single Act will require substantial revision and reworking of existing legislation. The purpose of this appendix is to provide a more detailed review of current legislation than is feasible in the main body of the report. The Public Health Act and The Health Services Act will be referred to as PHA and HSA, respectively.

The Committee suggests that three main sections be established regarding the role of regional boards:

1) the general duties and powers of regional boards

2) the operation of pilot projects

3) the appeal process

These sections can be developed in accordance with the recommendations outlined in this report. The following changes are proposed for existing sections:

- "supervise the public health services of the region" rather than health services (HSA, section 6).

- remove authority to "own and operate hospitals, health centres, etc. and to make arrangements for personnel to provide such services" (HSA, 7(1)a, b).

- replace "health services" with "public health services" (HSA, 2a, b, c, e, and f).

- "review annual estimates presented by the Regional Director" rather than submit estimates to the Minister (PHA, 5b, 6c; HSA 9).

- delete registration of residents (HSA, 10).

- regional boards be made up of municipal representatives rather than members of district health councils (HSA, Regulations, 8d).

- delete reference to planning and provision of health services (HSA, Regs., 8e, 10a, i-iv).

- remove authority to employ people to carry out the work of the board (HSA, 2f, Regs., 10b).

- delete references to district health councils (HSA, Regs., 8c).

- delete submission of expenditures by board of health to municipal council (PHA, 18, 1).

- delete employment of sanitary officers by municipal councils (PHA, 26).

- remove power of municipal councils to expropriate land (PHA, 39-40).

- delete submission of an annual report to the Minister of Health by the municipal council (PHA, Regs., 26).

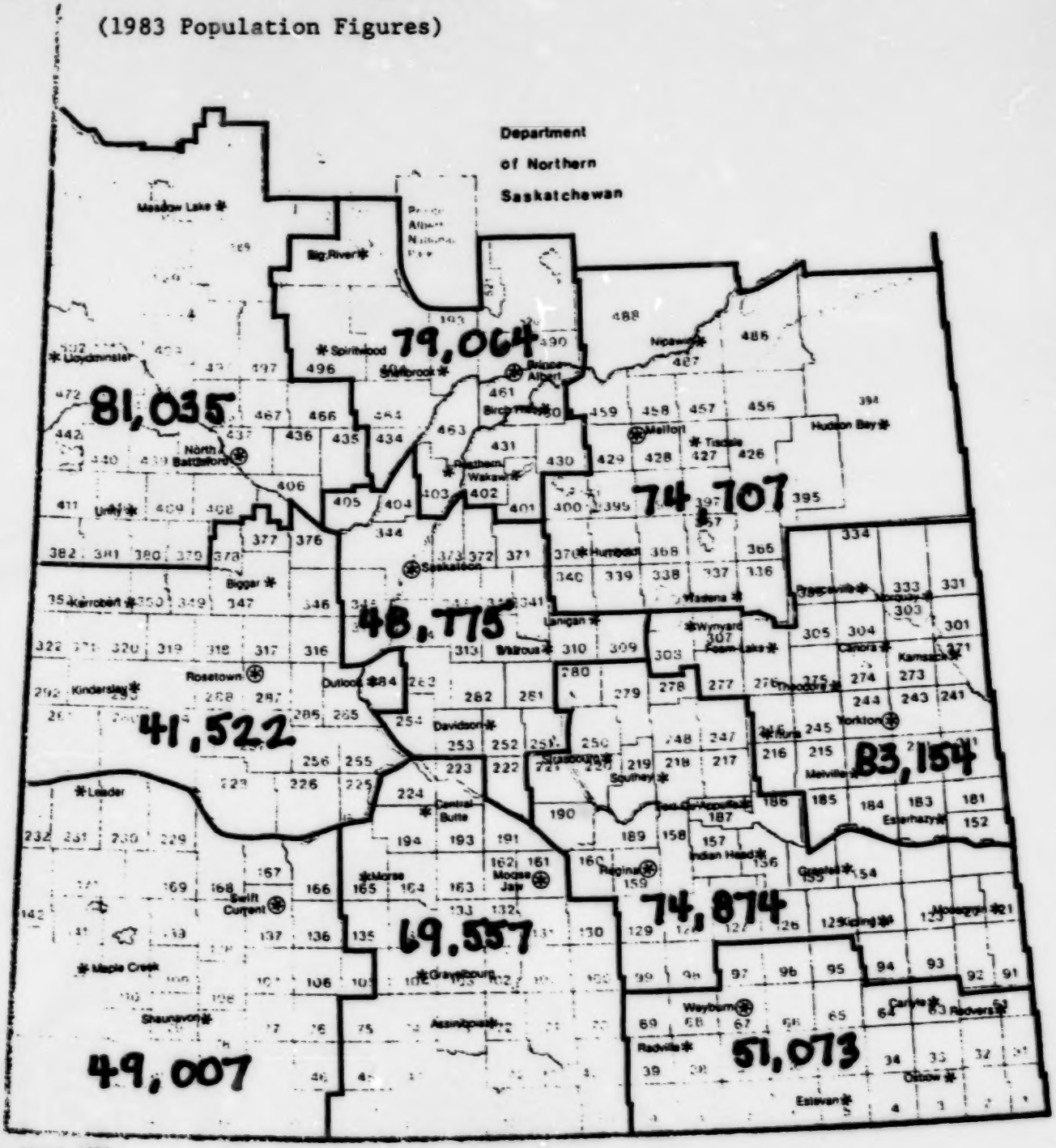
- delete provision of medical care, etc., payment of physicians, joint provision of services (HSA 24, 26-28, 30, 38, 42).

There would appear to be some duplication between the Acts themselves and between the Acts and the regulations. There are also a number of sections in The Rural and Urban Municipality Acts pertaining to public health. Powers of municipalities include enforcement of bylaws, taking care of nuisances (at the owner's expense, if necessary), making grants for the "health and welfare" of citizens, and operating a hospital or health centre. These provisions need to be examined to avoid unnecessary overlap or duplication.

Figure 4 . Health Regions

APPENDIX B

(1983 Population Figures)



March, 1980

Key:

No. 1 Swift Current (48,361)
No. 2 Moose Jaw-Assiniboia-Gravelbourg (69,659)
No. 3 Weyburn-Estevan (50,613)
No. 5 Regina Rural (64,508)
No. 7 Rosetown-Biggar-Kindersley (41,466)
No. 8 Saskatoon Rural (45,391)
No.10 Yorkton-Melville (80,641)
No.11 Melfort-Tisdale (72,134)
No.12 Prince Albert (70,647)
No.13 North Battleford (69,496)

Note: Population served is given in parentheses - SHSP Covered Population at June 30, 1979, excluding Registered Indians, Regina, Saskatoon, and Northern Saskatchewan.

⊛ Regional Office
* District Office